



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

GILBERT MAYORGA

**Respondent Name**

AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**

M4-14-0840-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 12, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** The requestor did not provide a position statement.

**Amount in Dispute:** \$500.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "See attached rationale for billing dispute from Coventry Workers' Comp Services dated 11/20/13. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

| Dates of Service | Disputed Services    | Amount In Dispute | Amount Due |
|------------------|----------------------|-------------------|------------|
| April 18, 2013   | CPT Code 99456-WP-W5 | \$500.00          | \$500.00   |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – Claim/service lacks information which is needed for adjudication

**Issues**

1. Did the requestor bill the disputed services in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. Per 28 Texas Administrative Code §134.204 states “(i) The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall in ... (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection. (3) The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.”  
  
Review of submitted documentation finds DWC-69 which indicates the performing doctor performed a Designated Doctor Examination to address maximum medical improvement and impairment rating with one body area rated using Diagnosis Related Estimate (DRE) method. Further review of division records finds a DWC-32 (Request for Designated Doctor Examination) requesting maximum medical improvement and impairment rating evaluations which the Division approved and scheduled on the disputed service April 18, 2013. The total reimbursement for CPT Code 99456-WP-W5 is \$500.00 Therefore CPT Code 99456-WP-W5 is supported.
2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, additional reimbursement in the amount of \$500.00 is recommended for CPT Code 99456-W5-WP

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

7/25/14  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**